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Current provisions and practices in the United States of America relating to the commitment of opiate addicts

Abstract

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In this paper, which relates to conditions in the United States, the term "addict" will refer to the opiate addict. Cocaine abuse is not at present a problem in the U.S.A. While there is an extensive use of cannabis, generally smoked as marihuana, this is usually in the form of intermittent, sporadic and occasional dissipation. The heavy constant use of this drug, characteristic in some other countries, is here somewhat rare. Marihuana users are not as recognizable or as identifiable as are opiate addicts.

Today in the United States the opiate addict, in the great proportion, is a consumer of heroin (diacetylmorphine). Only a very few will have access to smoking opium. Next in number after the heroin users will be a relatively small group of addicts who are able to divert drugs from medical sources. These will be users of such drugs as morphine and hydromorphone (dilaudid) or the synthetic pethidine (demerol). Addicts hard pressed for sources may resort to opium mixtures such as paregoric (camphorated opium tincture), or to other medicinal combinations containing small amounts of narcotics such as hydrocodone.

Markind's search for a cure for opiate addiction has followed a long and difficult road. It begain in that far

distant day when there first dawned the full realization that - along with the silken caress of a most beneficent medicine or the seductive euphoria of one of the most fascinating drugs of dissipation - opium could sink into an unwary or heedless victim the steel barbs of a demanding dependency.

Specific means and medicines for curing opiate addiction were not easily discernible or readily available then, and they have not been found even to this day. As cogently stated in the 29 November 1960 report of a British Inter-Departmental Committee on Drug Addiction, "Information about the ultimate prognosis for drug addicts is extremely scanty and, so far as we can ascertain, the long-term results have hitherto been disappointing. This may reflect both the intractability of the condition and the inadequacy of the treatment. Prevention, obviously, is to be preferred to cure...."

So long ago the emphasis for "cure" was placed on prevention. That ounce of prevention, which in our proverb is worth a pound of cure, weighs heavily in the scale, however. It takes the form of legislation in most of the civilized world restricting the commerce in opiates. It encompasses one of the most far-reaching programmes for international control among the countries of the world. It has been a long-standing concern of the original League of Nations, and now of the United Nations. Medicine has developed techniques so that the danger of addiction as an incident to medication is minimized. Dedicated scientists have spent life-times, and pharmaceutical manufacturers fortunes, to develop drugs which would have the positive virtues of the opiates as medicines without the addicting danger - so far without any great success. All these efforts, however, have brought gains, sometimes small and hard won measured in the short span, but a solid and substantial advance over the long years. For example, we are now far past the stage where a drug like heroin could be advanced as a cure for morphinism, only to deepen the degree of addiction. Despite a present flood of new drugs, we may hope we also are beyond the stage where not too long ago the addictive qualities of pethedine were initially underestimated to the detriment of many people.

Despite the developments in medicine and other science and the massive efforts of international and national control of drugs, some new addicts continue to appear and some of the older to persist. An abiding concern for the health and welfare of these as human beings as well as an appreciation of the danger which they represent to their contemporaries as a source of contagion have prompted discussions of many programmes for their cure and rehabilitation. In the past few years in the United States of America, we have seen a quickening of interest in these proposals, and it is the purpose of this paper to discuss some of the aspects of this situation.

History of narcotic addiction, U.S.A.

Before undertaking that task, it might be well to attempt to put the opiate addiction problem in the United States in proper perspective. At the moment, in comparison with many other situations with which medicine and law enforcement are confronted, the opiate addiction problem in this country is a small one. This is so speaking only relatively and as to the specific situation today. The danger is here when we have any addiction. We have had our warnings in our former high incidence of drug addiction late in the 19th century and early in the 20th century, and in the flare-up of heroinism in the late 1940s after World War II.

It can be said with some confidence that the number of persons in this country now actively addicted to opiates is about 50,000. Certainly this does not loom very large in a nation with a population of over 182,000,000. This number, of course, does not refer to persons taking drugs under medical supervision for intractable pain or for other medical reasons, but only to persons taking opiates merely to satisfy a dependency on the drug. However, it must be quickly emphasized that this has not always been the American picture of drug incidence. In the last half of the 19th century, opiate addiction, as well as the use-

of cocaine, acquired a great impetus and was rapidly rising. This continued into the first decades of the 20th century. At its high point, approximately one person in every four hundred of the American populace was a victim of narcotic addiction. The daily intake per addict was very heavy, often ten to twenty, sometimes fifty grains of morphine or the equivalent in heroin. So substantial was the individual narcotic intake that a good proportion of the users of opiates coincidentally took cocaine to counteract the drowsiness of overadministration of the opiates, and for the peculiar thrill and experiences from the intake of the combination of these drugs. In 1915 the first comprehensive American laws went into force seeking to curb the traffic in narcotics. Paralleling these, there was the effect of such international actions as resulted in the limitation of drug manufacture. With the enforcement of national and international restraints against narcotic commerce and the development of medical knowledge, the number of addicts began to show a steady decline. At the outbreak of World War II the incidence of addiction had dropped to about one addict in three thousand of the population, and the daily intake per addict was light. The illicit use of cocaine had disappeared. When World War II forced what was practically a total embargo of opiates on the country, addiction almost disappeared. That condition persisted until about 1947, when there was a flare-up, but a temporary one, of cocaine use. Developing along with it was a continuing new incidence of opiate addiction. Addiction again rose to a ratio of about one in three thousand. Since about 1956 it has been declining, and is now about one in four thousand.

In re-emergence opiate abuse differed in many respects from its original manifestations in this country. While early in the century most addicts tended to congregate in urban areas, there nevertheless was a rather uniformly occurring incidence throughout the whole country. Whereas male addicts were in a small majority, there were many females. As law enforcement continued to bear down, the relative proportion of females became less.

In the post World War II manifestation, opiate addiction did not reappear in any significant degree in most of the areas of the country. It is rather sharply confined to certain specific cities. In the state of New York its re-emergence was principally in New York City. In California, addiction increased in cities such as Los Angeles, San Francisco, Oakland and San Diego. In Illinois, the new addiction was mainly in Chicago; and in Michigan it was in the city of Detroit. Whereas in the early decades of the 20th century the addicted group was primarily of Caucasian or Chinese derivation with a good proportion of females, there now appeared on addict population in which males predominated in a ratio of four or five to one. About 59% were Negroes. Many were in a younger age group, in the late teens or early twenties. (New addicts in this age group, mostly white males, had appeared in some numbers at the end of the First World War.) It was the relative youth of the new addict group which perhaps gave the greatest impetus to new efforts to establish cures and rehabilitation for these people.

Incidentally, there is some indication that the pattern of increasing age seen in the addict group between our two world wars may be repeating itself. A statement on narcotic addiction by the U.S. delegation at the sixteenth session (1961) of the United Nations Commission on Narcotic Drugs points out that now only 0.3 of 1% of reported addicts are under eighteen years of age. Another 3.6% are 18 to 20 years of age. There has been some decrease in the incidence of addiction in the age group 21 to 30 years, which now stands at 52.4%. The incidence in the 31-40-year age group has shown a slight increase, and now stands at 33.3%. Addicts over 40 years of age showed a decrease from 1959, and the number reported now stands at 10.4% of the total. Putting it another way, these figures seem to reflect that the younger person appearing with frequency in the late 1940s and early 1950s is not becoming addicted in such numbers and, should the present trend persist, with the passage of years the group then addicted and persisting inevitably grows

older.

Characteristics of narcotic addiction, U.S.A.

We should point out a rather unusual characteristic which relates to the majority of the American opiate users today. The physical addiction is generally mild - that is, the narcotic intake is small. The available illicit narcotic is predominantly heroin, but in a very dilute form, generally less than 10% in a mixture of sugars and other diluents, such as quinine. Often the concentration is less than 10%. This is coupled with a continuing high price all along the line - $12,000 to $15,000 per kilo to the smuggler or prime dealer for pure heroin; $500 to $1,000 per ounce to the wholesaler for heroin of approximately 50% dilution and ranging down to $10 for a capsule containing 1 to 2 grains of a sugar mixture with from 2 to 10% heroin.

Economically, chemically and physiologically the American addict finds it difficult to pump into his system enough of this admixture of much dross and little heroin to develop any marked physical dependence. The result then, in an inland city like Chicago, is that in a group of twenty persons regularly using heroin when arrested or otherwise detained, only about one person on deprivation might show opiate withdrawal symptoms of any severity. The reactions of the remaining users would not go beyond some restlessness and uneasiness, some yawning, a little sweating and perhaps a slightly runny nose. It would be the opinion of most narcotics officers that when sufficient drugs of good quality became available the narcotic intake of most of these people would be stepped up to conform to the available supply. Occasionally there will be seen an addict who develops the classic withdrawal syndrome with real intensity. More often than not he will be one of the few who, through theft or by fraud and deceit, has access to medical opiates. Sometimes the heavily addicted person will be an underworld character, perhaps a prostitute or a thief of high income who has established lines to obtain heroin of relatively high concentration.

Our problem then is the medical and rehabilitative handling of about 50,000 addicts in a few of our larger cities, and these will be the only areas in which any elaborate special measures are justified. Most of the addicts will be found to come from slum neighbourhoods where crime and vice flourish. When queried by narcotics officers as to the genesis of their addiction, they will give answers to indicate that the habit developed in the overwhelming majority from social contacts with other addicts. Often the proselytizing was positive, sometimes negative; often there might be the element of challenge to prove that one was not "chicken" (cowardly). Often there was the factor of imitation and desire to belong. Obviously often present but seldom expressed was the element of resentment at an assumed inferior position. Often experimentation with cannabis or the barbituates preceded opiate addiction.

It must be emphasized that by and large the American addict is a user of a contraband drug, heroin, which is entirely outlawed in this country and has no medical use here. The typical addict gained his knowledge of and his access to heroin in the criminal underworld. Seldom has any of these had contact with physicians or other sources of medical opiates, except that the experienced addict may later come to learn how to procure morphine, dilaudid and the like by thefts from pharmacies, by forging prescriptions or by other fraud and deceit.

Since programmes based on laws and regulations must be comprehensive, mention must be made of another addict group. These will be very few in number, of no consequence as influencing our final figures but one of prime interest in what they illustrate about the genesis of narcotic addiction and its cure. These are the medical doctors and some paramedical people. Early in this century the incidence of addiction among these professional people was often estimated at about 2%. Now it is undoubtedly much lower. Within the past two years newspaper accounts have quoted some U.S. medical leaders as estimating that the incidence

is still about 1%. The fact is apparent that the medical profession has by far the highest incidence of narcotic addiction of any body of comparable education, intelligence and prestige. This feature is not unique in the U.S.A., but is recognized in many other countries. Here of course is an exception to the theory of social contagion. The constant factor is that the medical man has continual access to and to some degree an autonomous discretion as to the use of opiates. While the medical group is interesting from the standpoint of the acquisition of addiction, it also represents one of the hopeful illustrations of its cure. Generally after some sort of an intervention, usually in the form of professional associates or family, or sometimes the law, about 90% of these doctors may be cured, according to the experience of the California medical authorities. [William F. Quinn, M.D., *Bulletin,* Los Angeles County Medical Association, 3 April 1958.]

The author's own experience in the Illinois Division of Narcotic Control and in the Federal Bureau of Narcotics leads him to believe that this figure is generally attainable.

Necessity for addict control

Most informed people will recognize the danger of the addict at large in the community in any narcotic control programme. Because he must have drugs three or four times a day to supply his own habit, he is the first line to a narcotic supply and the prime source of information as to where opiates may be found. In contact with the dissipation-prone hedonist, he is the fountain of propaganda and proselytizing which transmute into the "milk of paradise" what would otherwise be harmless dross.

Furthermore the typical American opiate addict, if he possesses any means, is a drone or worse, and a heartbreak to his family and his friends, if any remain. He is most likely not to have means, as he would soon dissipate them. If not primarily a police problem - and in the American setting it is likely that he was - he now becomes one, and depredations as a thief and swindler or in other crime are his constant preoccupation. It is highly important then for many reasons to disintoxicate this addict and try to effect some sort of a lasting cure of his addiction. How to bring this about has been the subject of much discussion and some accelerating action.

The federal narcotic hospitals and their contributions

Treatment for the addict's addiction and his rehabilitation have long been a part of the American narcotic control programme. Two large federal hospitals were opened, one at Lexington, Kentucky, in 1935, and one at Forth Worth, Texas, in 1938. Each hospital is capable of handling a patient population of about a thousand. At Lexington there are separate facilities for about two hundred women. The Forth Worth hospital has not in recent years been used to full capacity for narcotic treatment. The addict population there now ranges near the 450 mark. These hospitals came to serve several purposes. They were to afford hospital care to addicted persons sentenced to imprisonment either for violations of the federal narcotic laws or other federal crimes. The effort is made to treat the addict for his addiction and other ills. All or only part of the addict's sentence might be served in the hospital in line with policies established between the hospital authorities and the Bureau of Prisons. Under the law and procedure, sentenced prisoners have the first claim on the narcotic hospital space. In practice this has allowed for the utilization of a number of beds, about 50% of the total, for civil patients. These are non criminal cases where the addict volunteers for treatment. Since the recommended period of stay in the hospital averages about five months, in a year's time the institution ideally might handle a population of civil addicts of about twice the number of beds designated. By no means do all civil addicts who obtain admission to the hospital as volunteers remain there for the recommended period. Some do not choose to continue treatment. Some are so impressed with the quickly acquired sense of well-being, that they leave against medical advice. When the hospitals were first opened an attempt was

made to follow a policy of keeping the volunteer in the institution until he had received maximum benefits. However, the question was soon tried in the courts and the rule established that the volunteer addict was free to depart whenever he chose.

It should not be assumed that the federal narcotic hospitals fully meet the institutional needs in this field. As indicated, the federal hospitals have no means of ensuring that patients who come there other than as federally sentenced prisoners will receive the full course of treatment. Many patients who come as volunteers leave against medical advice. Commenting on this, Dr. James V. Lowry, one-time medical officer in charge of the Lexington hospital, said "We have had a long experience with voluntary admissions and I can cite you facts on this. If you take a study which has been done of 765 consecutive admissions of voluntary patients you will find that 40% leave within the first two weeks. This means that many leave within the first 24 or 48 hours and so on. Then you will find another 15% leave in the second two weeks and an additional 15% before the hospital feels they are ready to leave. I can say there is nothing more frustrating to the medical staff than to invest a lot of money and a lot of effort in these people who depart while they are still receiving narcotic drugs as part of their withdrawal treatment." [Proceedings of Conference on Post-Hospital Care and Rehabilitation of Adolescent Narcotic Addicts. Albany, N.Y., Jan. 1960.]

The federal narcotic hospitals long have been emphasizing that an essential part of any comprehensive cure or rehabilitation programme for narcotic addicts is a follow-up system in the community. The federal institutions cannot operate directly in this field, which is essentially one for state or local action. Indeed, these hospitals have not been able to devise a system which would give them an actual history of results accomplished with discharged patients. So the federal nature of the hospitals makes it difficult to fit them into a comprehensive rehabilitation scheme unless additional enabling legislation on the point is forthcoming. Nevertheless, a pilot programme by the United States Public Health Service is now under way in New York in which it is sought to make available to the Lexington discharge all of the local rehabilitation services which might be helpful to his case.

The physical location of the hospitals causes some persons to refuse to go there who might accept area hospitalization. Distance, the incidentals to admission and travel, fluctuating bed occupancy and other considerations may cause minor or considerable delays in admission. Often these are fatal to the final accomplishment of the admission of a vacillating addict. The willing prospective addict patient sometimes may get into serious difficulties with the law if his departure to the hospital is too long delayed. For these and many other obvious reasons, the proportion of the national addict population that benefits from federal narcotic hospitalization is relatively small. It can be increased if suggested federal legislation to permit of civil commitments by state courts to the hospital is enacted, and if more states enact comprehensive addict control laws which enable the authorities to require addicts to go to the Lexington hospital as part of their rehabilitation programme; but the need for local facilities for handling addicts will remain acute.

It cannot and should not be expected that the Lexington and Fort Worth hospitals can accommodate the entire prospective load. It is hoped that they will continue to remain as the prime source of information and guidance in the best methods of addict treatment.

Since these hospitals have a large population of narcotic addicts under controlled conditions, they presented an excellent opportunity for the testing of various chemicals and methods recommended as cures for addiction. These contributions of the Lexington and Forth Worth hospitals to the knowledge of opiate addiction have been extensive both in range and depth of study. The results have been invaluable. We have been spared from the too-free distribution of some new opiates first believed to be non-addicting or lightly

addicting, but later demonstrated to be quite dangerous. Some methods and drugs recommended as cures for narcotic addiction have been shown to be without value, or worse, or to have had insufficient scientific evaluation. One excellent contribution was the development of the use of methadone as a substitute drug of addiction in the rapid reduction of narcotic intake. The less severe reaction when the methadone dosage is stopped makes this a revolutionary accomplishment in the humane disintoxication of a narcotic addict who has developed a marked dependence on opiates. Another contribution was the demonstration of the use of nalorphine (Nalline) as an antagonist for opium, which would almost immediately precipitate withdrawal symptoms. From this addiction, control forces have developed a valuable working tool, as will hereafter appear.

Theories of opiate addiction treatment

However, all the study and experimentation which have gone on here, and the world around, find us still lacking two hoped for tools against narcotic addiction; nor is there any assurance these will be developed in the near future. First there is as yet no non-addicting opiate. "A potent analgesic which is not addiction producing has so far not been forthcoming." [Drug Addiction Report of the Interdepartmental Committee, 1961. Britain, supra.] Second, as we have indicated, there is no specific drug, no chemical cure for addiction. [As this is being written there is a note in The New York *Times,* 25 June 1961, quoting Dr. Paul O'Hollaren of Shadel Hospital, Seattle, Washington, in the *Western Journal of Surgery, Obstetrics and Gynecology*, concerning experiments with a chemical, the coenzyme diphospyridine nucleotide, as enabling addicts "immediately and permanently" to stop using narcotics. Dr. O'Hollaren cautions that it may take several years for final evaluation of the treatment.] Many "cures" have been recommended in the past, only to be finally discarded as useless or worse. The future may bring valuable discoveries in the pharmacological field, a consummation devoutly to be hoped for. But there must be the most cautious approach to the appraisal of the real worth of the claim of "cure ".

Of course there are means, methods and processes which may help towards cure, but they are to be relied on hopefully rather than confidently. One of the most obvious of these processes is that the narcotic addict can be rather promptly "detoxified" by being separated from the drug of addiction. As indicated, this may now be done without great discomfort, and the methadone substitution method greatly reduces" fearsome" withdrawal symptoms. These are fearsome at least to the extent that they are persuasive to the addict to keep up his drug intake, often to commit crimes to ensure his supply, sometimes to cry out as if in mortal agony when deprived of it. But too often the recollection of withdrawal pangs is not fearsome enough to convince him that once "off drugs" he should not resume the habit.

[Fear of consequences dissuaded one abstinent addict from reverting to drugs, in the author's recent experience. This entertainer and confidence man (swindler) had a big income and a heavy drug habit. Addicted for about fifteen years, he had had several arrests and prison terms, but always quickly reverted to his addiction. More than a year ago he developed a staphylococcus infection from an unsterile needle - was ill to the point of death, but survived. Now he manifests a blend of longing and antipathy toward addiction. The antipathy has so far kept him abstinent.]

But separation from his drug is only a first necessary step and there is a compelling impulse on the part of many to relapse to drug use. Most medical writers stress that a fundamental premise for treatment of narcotic addiction is that the addiction to drugs is but a symptom of the basic personality derangement. [K. W. Chapman, M.D., Care and Treatment of Drug Addicts, *Bulletin on Narcotics*, April-June 1958; Report of the Study Group of the World Health Organization, Treatment and Care of Drug Addicts, *Bulletin on*

Narcotics, July-Sept. 1957; James V. Lowry, M.D., Hospital Treatment of the Narcotic Addict, *Federal Probation*, December 1956; Isbell & Fraser *, Journal of Pharmacology and Experimental Therapeutics*, Aug. 1950.] Obviously such a concept cannot mean that all persons of this type become drug addicts in view of the varying, shifting and spotty incidence of addiction in this country. It might mean that many such persons would become addicts if the opportunity were presented to them in the way of access to drugs and proselytizing to their use. But obviously some such, presented with the opportunity, refrain from addiction. It is a difficult area in which to generalize.

The personality derangement concept implies that the patient receive whatever kind and degree of psychotherapy and other medical treatment as is deemed fitting and available. [Isbell & Fraser, *supra*.] As in some other medical fields, it does not appear that full psychiatric facilities for treatment of narcotic addicts will be available in this country for some time to come. Nevertheless, it seems that any narcotic hospital should be psychiatrically oriented and some adjunctive psychiatric facilities found in the community.

Various aspects of suggested programmes for the handling, treatment, care and rehabilitation of narcotic addicts in the U.S.A. have heretofore been discussed in the *Bulletin on Narcotics.* Among these are "Treatment, Care and Rehabilitation" by Nathaniel L. Goldstein, May-August 1954; "Treatment and Rehabilitation of Narcotic Addicts", Report of the Committee on the Judiciary of the United States Senate, July-Sept. 1956; and "Care and Treatment of Drug Addicts" by Kenneth W. Chapman, M.D., April-June 1958. An article of greater geographical scope is "Treatment and Care of Drug Addicts - A Report of the Study Group of the World Health Organization ", July-Sept. 1957.

Most authorities in the narcotics field will agree that one very logical procedure in the detoxification of a narcotic addict is to confine him in a drug-free situation. For the addict convicted of crime this might be in the hospital facilities of a penal institution. For the addict not under any conviction some process which would ensure his hospital detention for a sufficient time to bring about detoxification and the necessary physical and mental readjustment would seem to be desirable.

Diversity of programmes for U.S. addicts

For other than the U.S.A. reader, it should be pointed out that under this government, which is a union of states, countrywide uniformity in the physical handling of addicts for treatment and rehabilitation is unlikely. The powers of the central federal government are strictly limited constitutionally. They are confined to such areas as international relations, defence, the monetary system, interstate commerce and the like. Police powers generally are reserved to the states. So conceivably the law and practice in each of the fifty states might differ in some degree in provisions made for the handling and commitment of addicts. Most of the states now have laws by which narcotic addicts may be civilly committed for observation and treatment, the process being somewhat similar to that followed in committing insane persons. In some fewer states narcotic addiction may also be a crime, generally a misdemeanor. In actual practice the civil commitment is very infrequently used in many of the states. In the first place, as pointed out above, rather few of the states in number now have any considerable narcotic problem. In some others the civil commitment procedures are not too workable. Sometimes when it might seem desirable to invoke civil commitments for addicts for treatment, that practice is not followed, for local considerations. For instance, in some states the expense of a civil commitment and treatment must be borne by the county or local authorities, and there is an understandable reluctance in local bodies to incur such special expenses.

A further factor affecting uniformity in the civil handling of addicts for medical treatment is that public hospitals are likely to be considered the responsibility of either a municipal or a county government. While

the federal government may assist, usually in the way of a grant of funds for construction, and this seems to be increasingly the trend, the initiative must come from the local governmental bodies. A conception of this diversity will be of assistance in understanding the discussion of the actual experience with narcotic addict controls and cures in several areas of this country.

New York programmes

In point of numbers, New York State has our most serious narcotic problem. The latest estimate of the Federal Bureau of Narcotics is 20,648, about 46% of the estimated national addict population. [Hearings, House of Representatives Appropriations Subcommittee, Treasury-Post Office for 1962 - March 1961.] These addicts for the most part are concentrated in New York City, in certain slum areas. When the alarming renewal of narcotic addiction began in the late 1940s and early 1950s, many people in New York became gravely concerned. One of the major investigations was made by the then Attorney-General of New York, Nathaniel L. Goldstein. In 1951 and again in 1952 he submitted reports to the legislature recommending additional narcotic legislation and called for the compulsory treatment of addiction. In 1954 his successor as Attorney-General, Jacob K. Javits (now U.S. senator) also reported to the legislature on the narcotic stituation. Among other things, he recommended mandatory after-care clinics for persons arrested for narcotic offences, to be linked to the state parole and probation system, a specialized hospital facility for addicts, and that the state courts be given power to commit narcotic addicts as patients to the U.S. Public Health Hospital. In 1956 a joint New York State legislative committee on narcotic addiction was set up. It has studied the New York situation extensively and exhaustively. Its reports - such as the 1959 report, New York legislative document No. 7 - are illuminating. Another significant document in this field is a report of the proceedings of a conference on the post-hospital care and rehabilitation of adolescent narcotic addicts under the joint auspices of the Governor's Task Force on Narcotic Addiction, the New York State Interdepartmental Health Resources Board and the New York Board of Hospitals. A meeting was held at Albany, N .Y., in January 1960. The reports just alluded to do more to reflect the immense perplexity which surrounds the narcotic addict "cure" problem than to disclose any dramatic success in finding a solution to it.

At the Albany meeting Ray E. Trussell, M.D., of the Columbia University School of Public Health and Administrative Medicine, in reporting on a study of Riverside Hospital dischargees, made these observations in his introductory remarks. These are quoted rather extensively, because they illustrate some of the perplexities of the problem. "The Riverside Hospital program was established in 1952 as a result of the growing city, state and public concern with an apparent increase in drug users among persons under the age of 21. No similar institution has ever been devoted to the treatment and rehabilitation of the adolescent drug user. It follows therefore that the Riverside Hospital is a social as well as medical experiment which is entitled to the same objective appraisal as any other community health facility. It is the purpose of the present report to provide assistance in such appraisal. Any organized program dealing with the problem of drug addiction is faced with the historical fact that no therapeutic success of any significance has ever been recorded." Dr. Trussell then went on to point out that the survey had shown the Riverside Hospital programme to have had difficulties in both its services and research programmes. Low salaries and geographic location were obstacles to obtaining an adequate psychiatric set up; the hospital grounds were small, facilities for work programmes limited; many patients were over eighteen years of age and did not adapt to the school programme carried on at the hospital; there was an expressed need for a "half-way house" for patients after release from the hospital, to permit a more gradual return to the community; the after-care clinic suffered from inadequate professional staffing; the broken appointment record at the after-care clinic was very high; there was an unfilled need for social work staff visits to the homes and

communities of the patients to extend supervision and treatment. Service demands, understaffing and lack of funds precluded research by the Riverside staff as such, according to the survey.

The majority of patients entering Riverside Hospital for the first time were referred there by the courts on a variety of legal grounds. The court order permitted the treatment of the patient up to three years including after-care, which was to continue in the after-care clinic located in the metropolitan hospital.

A survey (commenced in August 1957) was made of all narcotic users (247) admitted to Riverside Hospital during 1955. It was found that of 218 (88%) of those who entered the hospital in 1955 and for whom records could be found, 85% had been either re-hospitalized for treatment of narcotic use or re-arrested, or both, one or more times. Another 10 (4%) reported by mail that they had returned to drug use, to drug use and police difficulty, or re-arrest. Eleven deaths constituted a very high death rate for the age group in question. Some recorded information indicated the majority were due to overdoses of narcotics. In the entire series of patients studied by record search, ten could not be further identified, and only nine had had no difficulties of the types described above.

Over all, the survey pointed out a grave picture of small concrete results in cure and rehabilitation of adolescent narcotic addicts under the Riverside programme. The conclusion of the conference was that the Riverside operation needed to be strengthened, some of its activities transferred, and that a strong research activity on narcotic addiction be developed in the hospitals in New York.

An interesting experiment was conducted by the New York State Division of Parole in relation to paroled prisoners with addiction records. Many parole and probabion people and law enforcement officers generally have been sceptical of the parole and probation processes as they applied to narcotic addicts. Results usually were poor due to the recidivistic tendencies inbuilt in the problem. In this country, parole and probation forces are chronically understaffed. Many probabion and parole officers did not have sufficient acquaintance with the addict-personality to cope successfully with the special problems he might present. To meet some of these difficulties, a programme was conceived and put into operation by Travers, Diskind and others of the New York parole staff for an experimental group of parolees to be intensively supervised by parole officers with particular knowledge in the narcotic addiction field. This was undertaken in 1956. At first an attempt was made to select parolees 21 years of age and under, but because an insufficient number of youths with narcotic records were being released from the state correctional institutions the age limit was raised to 25 and later to 30 years. The parolees had all been heroin users for at least six months. In one respect they might not have been strictly typical, as an attempt was made to select those whose addiction to opiates seemed to have preceded a record for criminality or whose pre-addiction record for criminality was light. The object was to give the parolee intensive supervision, and a maximum case load for each parole officer was set at 30. The usual case load is about twice that. The project covered four such case loads, or a total of 120 parolees. No extraordinary techniques were employed. The parole officer attempted to maintain a close and friendly relationship with the parolee, counselling him in his difficulties and helping him with job opportunities and the like. A major decision was to be somewhat tolerant of the occasional user. The disposition was usually to give him another chance, and this was found to be constructive in some cases.

Such a close relationship was maintained between the parolee and his supervisor that relapses to the use of narcotic drugs usually were disclosed rather quickly. Many relapsing or experimenting parolees would voluntarily disclose the facts to the parole officer. Nalline was not used to check for relapse, those responsible considering they were sufficiently familiar with the parolee that they would soon detect any real relapse to drug use.

For a three-year period, 35% of the parolees were found not to be delinquent for any reason whatsoever. 45% of the whole case load abstained from narcotic drugs while under supervision. (However, in this group, representing 119 people, there were 55 who had been in the project for less than 6 months. Most relapses are found to take place within that period.) While the group of parolees was small and the period relatively short, it would seem from the results that here is a demonstration of a promising area for the rehabilitation of narcotic addicts convicted of crime. This approach now has been made part of the permanent operation of the New York State Division of Parole. [An Experiment in the Supervision of Paroled Offenders Addicted to Narcotic Drugs (1956-1959), Final Report, New York Division of Parole.]

A modification of this technique of close supervision for convicted narcotic addicts as well as those civilly committed has been developed in California and adapted in Illinois. This will be discussed further under those areas.

For many decades New York State has had legislation providing for the voluntary commitment of drug addicts. The law provided that on voluntary application of any habitual user of a narcotic drug the magistrate might commit such person to any hospital or charitable institution maintained in whole or in part by the public, which would receive such an addict. A procedure developed whereby magistrates committed such addicts to facilities under the New York Department of Correction. The period of commitment was normally two weeks to allow a detoxification of the addict. In 1959, following objections from the Department of Correction to receiving these addicts, the New York City Department of Hospitals accepted the responsibility for addicts who committed themselves voluntarily.

Early in 1960 the New York State legislature enacted a law authorizing the civil commitment of addicts following the general certification procedure for the mentally ill. However, the commitment period, including follow-up supervision, is for one year only. The legislature also provided that the Mental Hygiene Commissioner establish wings or wards in one or more state hospitals for the study, care and rehabilitation of drug addicts who voluntarily apply for admission or are admitted on court certification. At present, the specialized narcotic treatment facilities in New York are limited to what might be termed experimental programmes. Among the New York City facilities are Riverside Hospital for adolescent addicts with about 140 beds, Metropolitan Hospital with 25 beds for male adolescents and 25 beds for male adults, Kings County Hospital with 25 beds for male adolescents, and Manhattan General Hospital with two wards (60 beds) for males under contract. The New York State Department of Mental Hygiene has at Manhattan State Hospital a project for 55 beds for male adults. Additional state projects are contemplated at Central Islip State Hospital (80 beds) and at Utica State Hospital (20 beds).

California programmes

California is another state which has been devising and surveying programmes for the rehabilitation of narcotic addicts. The estimates of the Federal Bureau of Narcotics put 7,411 addicts in this state as of 31 December 1960. This is 16.5% of the national addict population estimate. [Hearings, House of Representatives Subcommittee on Appropriations. Treasury-Post Office for 1962 - March 1961.]

For many years, California had two particular methods by which a narcotic addict might be handled by the law. The first made it a misdemeanour to "use, be under the influence of or be addicted to the use of narcotics..." (except when administered by a physician). A convicted person would be sentenced to not less than 90 days or more than one year in jail. He might be placed on probation for five years, but in no case would he be absolved by a court from 90 days' confinement. In many instances, the sentence was to road

camp, forestry camp or honour farm operated by the jail system. The second method was by civil commitment to a state hospital. This involved the filing of an affidavit, the issuance of a warrant by a magistrate, followed by court hearing of medical testimony relative to the addiction. Then if the patient "is not of bad repute or bad character apart from his habit" he might be committed to one of the state hospitals for "not less than 3 months or more than 2 years ". This second method was entirely civil. No criminal record was made. The release was not voluntary, however. Persons were released after the prescribed treatment as cured, or with the statement that further treatment would not be helpful. An interim report (9 Dec. 1960) of the Special Study Commission on Narcotics appointed by Gov. Edmund G. Brown states that admissions to state hospitals under the civil provisions are few. The Department of Mental Hygiene was accepting only persons who voluntarily requested such commitment. In 1959 only 42 beds were used in all the state hospitals, and a total of only 168 addicts were accepted for treatment.

California has been the site of an interesting experiment in the use of nalorphine (Nalline) in the attempted control of opiate addicts. Following notice of its use as an opiate antagonist by Isbell and others in the Lexington Federal Hospital, Dr. James G. Terry, Psychiatrist and Medical Director of the Santa Rita Rehabilitation Clinic, Alameda County, California, began some extensive experiments. Dr. Terry eventually determined that a small dosage of Nalline (3 mg) would rather promptly produce enlargement of the pupils of the eyes of an opiate user, the change depending to some extent on the degree of dependence to the opiate. Yet the dose was small enough so that severe and disagreeable withdrawal symptoms would not be produced.

In any system of addiction detection it is invaluable that there be a quick and accurate method of determining whether the subject is a user of opiates. This the Nalline technique supplies.

Within limits it will immediately indicate not only the heavy user without the delay necessary for the normal onset of withdrawal symptoms, but will also help detect the light addict who would not develop the typical withdrawal syndrome with any intensity. It will also indicate the beginner or recent casual user.

Alameda County has a population of more than 900,000, the largest city being Oakland, Calif., with a population of over 367,000. This is across the bay from San Francisco, and there is a large daily exchange of people, underworld types included.

When Dr. Terry's techniques with Nalline became known to narcotic enforcement authorities in Alameda County, there was quick, concerted action involving the office of the sheriff, in whose department belongs the Santa Rita Clinic, the county prosecuting authorities, the Oakland police, the courts and the probation and parole authorities. A plan was developed whereby a narcotic addict committed as such or for some other offence, after being detoxified and treated in the Santa Rita Clinic would be placed on probation or parole and required to report frequently for examination to determine whether or not he had relapsed to narcotic drugs. This examination was conducted by a physician, and one of the principal techniques relied on was the injection of a small amount of the opiate antagonist - Nalline - by the physician. The project began in 1956 and is still in full operation. While many factors tending to limit the narcotic traffic are present in San Francisco and Oakland, including strong enforcement programmes against narcotic traffickers, and the imposition of substantial prison sentences on dealers, all of the law enforcement and medical officials concerned with it are certain that the Nalline programme has contributed a substantial part in reducing the incidence of relapses to narcotics by addicts, and it has enabled the authorities to detect very quickly those who do relapse before a serious rate of addiction can be resumed. Also in the opinion of the authorities it has greatly reduced the class of crime usually perpetrated by addicts. ["Three Years of Nalline", by Lt. Ted

Brown, Oakland Police Department, *Police,* May-June 1961. *The Enigma of Drug Addiction, Brown.]*

In essence, this programme is one of close probation supervision in which the probation or parole supervisor has the added check of the Nalline device on the performance of his charge in abstaining from narcotic drugs. The case loads of the probation officers in Alameda County are in the neighbourhood of 60 probationers per officer.

Because of the likelihood that Nalline or other opiate antagonists may have an extended use in addict control programmes, it might be well to enumerate some of the claims made for and against the use of this drug. It has been found to be one of the fastest and most simple methods now known to detect opiate use. (Its reaction to demerol is equivocal unless the addiction is very heavy.) It has the disadvantage that it is a drug which should be administered by a physician under clinical conditions. However, there is much to be gained by having a physician present in the handling of a drug addict. Objections can be made to a technique which requires the introduction of a chemical into the person of a subject. Also, Nalline in sufficient doses may have pronounced effects on some persons. However, the drug has been administered thousands of times in the small dosage required without untoward results. The subject might well object to the administration of such a test as a violation of his civil rights. In practice, no person is required to take the test against his will. When the addict, showing indicia of addiction, such as old scars and fresh needle marks on his arms, nevertheless denies drug use, he generally will not refuse to take a Nalline test. When it is positive he usually capitulates quickly with an admission. The willingness of a probationer or parolee to accept Nalline, urinalysis or other specified tests for opiates can be a condition of his parole or probation. In parole and probation practices, the authorities in California, as well as those in Illinois and St. Louis, Mo., have found Nalline more than a detection device. Some former addicts, wishing to remain abstinent, were found to be relying on the prospect of frequent, and sometimes surprise tests for some support in keeping away from drugs. They seemed to find satisfaction in the interest and examination of the doctor; successful passing of the Nalline test was a source of pride and the accomplishment of the next test a good limited goal.

In October 1959, the adult parole division of the State of California commenced an intensified programme of parole supervision in the Los Angeles region of certain parolees with a narcotic history. In August 1960 another such programme was undertaken in the San Francisco area. These parolees were placed on weekly Nalline testing, and the case load for each parole officer was reduced to 30. The narcotic control and treatment centres were set up. Should a parolee revert to opiates, as indicated by a test failure, or should he appear to be in imminent danger of relapse, he was returned to one of the control units for 60 to 90 days. In present practice, on a first relapse the addict remains on parole; but in the case of a second relapse, the parole is suspended and he must personally appear before the adult authorities for a review of his case. [Personal communication to author from Walter T. Stone, Chief, Adult Parole Division, California - 25 May 1961.]

California now appears to be moving rapidly toward a comprehensive programme aimed at control treatment and rehabilitation of the narcotic addict. According *to The Correctional Review,* Department of Corrections, Sacramento, California, April 1961, plans are formulated to create a narcotic rehabilitation centre in the Department of Corrections, and provide for alternate means for court commitments for addicts to the Director of Corrections for custody and treatment. This facility and its programme would serve primarily to protect society through the removal of drug addicts from the community by their placement in this facility, where they would receive continuous control and intensive treatment, and intensive supervision on parole with quick return to the centre if necessary for fuller control and treatment. The plan contemplates the

accommodation of 1,800 male and 400 female addicts.

In June 1961 the California legislature enacted a law providing for the construction of a hospital facility in southern California for treatment of addicts, or persons in immediate danger of addiction by reason of repeated use of narcotics. This facility is to be in the Corrections Department. Convicted addicts, except those convicted of violent crimes, or for sale, possession for sale or a second offence for possession of narcotics could be committed to the facility for medical and mental treatment.

Persons convicted in courts of lesser jurisdiction of any crime, with certain exceptions, and who are addicts or in imminent danger of addiction, may be committed to the narcotic facility for five years. Similar persons convicted for any crime, with certain exceptions, in superior court (graver offences) may be sentenced to the facility for ten years.

Initially the addict must be confined in the facility for at least six months. Then he may be released under parole supervision. This supervision may be terminated as early as three years, or continued for as long as ten years, depending on the case and the recovery of the person committed from his addiction or imminent danger of addiction. The supervision shall include close observation of the parolee after his release from the narcotic facility, including but not being limited to periodic and surprise testing for narcotic use, counselling and return to an in-patient status, if the parole reports or other evidence indicate this is in the best interest of the parolee.

There is also provision for the involuntary commitment of addicted persons not charged with crime, after a hearing. Commitment is for a term of five years, unless discharged earlier.

The California law provides for the establishment of an experimental "half-way house" for addicts released under parole supervision. The law also provides for the registration of addicts convicted of crimes.

Having in mind that for many addicts a relatively short term of initial confinement (six months) is indicated, these measures should insure that a significant proportion of the California addict population can be reached for treatment, rehabilitation and control once the plans and facilities are in operation.

Michigan programmes

Michigan has one of the more substantial opiate addict populations, concentrated for the most part in the city of Detroit. The estimate of the U.S. Bureau of Narcotics as of 31 Dec. 1960 was 2,155. This represents 4.8 % of the total estimated addict population of the country.

With the rapid reappearance of narcotic addiction in the late 1940s, the city of Detroit became aroused. The mayor appointed a citizens' committee to look into the matter. This committee did excellent service in exploring the multifarious aspects of the problem. [Report of the Mayor's Committee for Rehabilitation of Narcotic Addicts, City of Detroit, 1953.]

A development of the early work of the mayor's committee was the establishment in Detroit, late in 1952, of a narcotic clinic as part of the Department of Health. Its out-patient facilities were closely related to the psychiatric division of Detroit Receiving Hospital and the Department of Psychiatry of Wayne University. The facilities of the clinic were offered to narcotic addicts, who were invited to avail themselves of these on a purely voluntary basis. The Detroit experience seems to be a most persuasive demonstration that the voluntary approach does not effectively reach any significant proportion of the opiate addict population. A survey by Herbert A. Raskin, M.D., Department of Psychiatry, Wayne University, of 510 patients seen in the

first three years of the clinic operation disclosed that only a very small proportion of these were truly voluntary admissions. The great majority, over 80%, came because of pressure from family or friends, cost or shortage of drugs, or because referred by probation officers or for fear of arrest or loss of a job, or similar stimulation. Of 164 of those actively addicted and withdrawn at Detroit Receiving Hospital, over 80% failed to return to keep post-discharge clinic appointments. In June 1954 the narcotic clinic offered its facilities by letter to persons shown by police records to be involved with narcotic drugs. The percentage return in persons seen was 3.9.

The Detroit Narcotic Clinic undertook to process patients for referral to the Federal Narcotic Hospital at Lexington, 400 miles away, as voluntary patients. Of 87 so processed, and whose applications were accepted by the hospital, only 52 actually reported there. Of these, 30 left the hospital against medical advice shortly after admission. Ten patients completed the minimal stay. Other patients of the clinic with whom Lexington hospitalization had been discussed refused to consider it because of the distance and for other considerations.

Because this and other experience seemed to demonstrate the impossibility of successfully handling the mass of addicts on a voluntary basis, Dr. Raskin and his associates in Detroit developed a plan for a pilot project based on the following principles:

1. The use of allegal instrumentality to commit the addict to compulsory hospitalization, as in other mental illness, and providing for immediate re-hospitalization when necessary within a period of at least two years following relapse.

2. A narcotic addiction rehabilitation hospital facility geographically located in the area of the residence of the addict and specifically oriented to effect withdrawal from narcotics and to initiate long-term medical, psychotherapeutic and social care.

3. A programme of continuing supervision of the patient following release, on a compulsory basis.

4. A follow-up procedure designed to maintain continuing information on the adjustment of the patient medically and socially. The patient is to be required to live within the legal jurisdiction of his commitment.

5. A continuing evaluation of the programme above outlined.

The plan contemplates utilization of a commitment law which in Michigan provides for commitment to any suitable institution of persons adjudged to be addicted to narcotics. This is on, order of the probate court. As envisaged in the plan, the original hospitalization in a specialized treatment facility would be short - 14 to 30 days for detoxification and intensive medical, psychiatric and social study.

Continuing care and contact following discharge will be on a compulsory "leave of absence" basis. This plan involves the use of a psychiatric out-patient mental health clinic, social rehabilitation and continuing evaluation.

Social rehabilitation will be attempted through the fullest possible utilization of the many specialized agencies in the city of Detroit which can contribute to employment, financial help, housing, training and education, recreation, social interests and the like.

A follow-up review will be employed immediately on release of the patient to give him all possible support and to quickly detect any relapse. Nalline may be employed as an adjunct in this phase of the programme.

The inception of the Detroit plan has been long delayed because of lack of finance. However, necessary funds now seem to have been found for putting it under way. Accommodation to handle about 200 patients during the first year is to be opened.

It now appears that there will soon be a well integrated and complete plan for the involuntary civil treatment of narcotic addicts in Detroit. The results will be interesting to watch.

Illinois programmes

Illinois has one of the more severe opiate addiction conditions in the U.S.A. The 31 December 1960 estimate of the Federal Bureau of Narcotics is a population of 6,533 addicts, 14.5% of the national estimate. Practically all of these addicts are concentrated in the city of Chicago and its environs. [House. of Representatives Appropriation Sub-Committee Hearings for 1962 - March 1961, *supra*.]

One of the first indications of a revival of opiate addiction in the United States was in the appearance in the late 1940s at the Lexington Federal Narcotic Hospital in Kentucky of an increasing number of addicts in their late teens, from Chicago. These began to augment and supplant a patient population which had been ageing into a late thirties characteristic before World War II.

Many programmes were devised in Chicago for combating the all too apparent rise in addiction, particularly among certain youthful groups. The Illinois legislature created a commission to study legislative remedies. This body had as its chairman State Senator John P. Meyer (who subsequently was to appear at the 15th session of the United Nations Commission on Narcotic Drugs with the U.S.A. delegation). The Commission made extensive inquiries on its own initiative. In addition, it had the benefit of recent studies by committees of the U.S. House of Representatives and the U.S. Senate, and of a Canadian senate inquiry. The Commission proposed much revision and new legislation in the narcotic field, and the legislature subsequently enacted much of this into law. [Illinois Narcotics Investigation Commission Report to the 70th General Assembly, 25 March 1957. Narcotics and Dangerous Drug Investigation Commission Report to the General Assembly, 15 May 1959.] Among other things, provision was made for the control of the narcotic addict. Under a law effective in 1958 it is a misdemeanor in Illinois to be addicted to narcotics or to use narcotics illegally. The penalty may be imprisonment for up to a year, but in no case may the addict serve less than three months in an institution. He may be put under probation with a sentence suspended for any additional sentence up to a year, and the term of probation may be for as long as five years. During this period, in addition to the usual probation supervision, he is subject as a condition of probation to routine or surprise testing by Nalline or other approved methods and techniques, Responsibility for setting the standards for such testing was placed by law in the Illinois Division of Narcotic Control, a central state agency set up to assist in the enforcement of the Illinois narcotic laws.

The Illinois law also provides that the state may elect, in lieu of prosecution of an addict as a misdemeanant, to commit him civilly to a state hospital or other facility suitable for the treatment of addicts. Originally the law provided a compulsory stay of three months in the hospital for the civil addict, but this was later modified to provide for release on medical advice. This was done to permit of a more elastic functioning of the programme. The law also provides for detoxification and treatment of addicts in private hospitals which meet certain standards where the addict patient is willing and able to incur the expense. Civilly committed addicts, under provisions of the commitment, are subject to follow-up testing procedures, including Nalline, if indicated, following release from the hospital.

Under the application of these laws, any addict who voluntarily asks for treatment is committed to a state hospital, or he may be allowed to go to a federal hospital or approved private hospital. Likewise, an addict arrested as such might be processed civilly rather than as a misdemeanant. This would be done if there was little or no criminal history. In actual practice, these cases are rare in Chicago. Addicts who are minors are referred to the Youth Authority.

Also, in actual operation, voluntary applicants for civil commitments for narcotic addiction are very rare. The great mass of narcotic addicts apparently do not have the interest or motivation to seek out treatment. As slightly qualifying this categorical statement it should be pointed out that Illinois has not as yet set up comprehensive facilities for the treatment of addicts, although these are being developed slowly. The crowded conditions of the state mental hospitals originally made them non-receptive to the admission of many addict patients. However, with the co-operation of the Federal Hospital at Lexington, accommodation was found for all volunteers who applied. It might be that if a specialized function such as the Santa Rita, California, clinic or one on the order of the narcotic hospital centre contemplated in Detroit were available, there would be more applications from addicts for civil treatment. However, the writer's personal experience under the Illinois statute suggests that these would still be relatively few.

A provision of the Illinois narcotic law calls for a special prescription for the more potent and dangerous forms of narcotic drugs. These prescriptions are centrally machine-addicted physicians. The results are interesting in any study of the cure of opiate addiction. They indicate that a member of this intelligent group composed of individuals with a high sense of values usually needs only the knowledge that his addiction has come to the attention of the authorities to undertake prompt remedial action. Generally, he quickly acquiesces in suggestions that he temporarily surrender his tax stamp (evidence of his right to prescribe or administer narcotics) to the federal authorities, and to put himself under the care of another physician for hospitalization. Only about one out of ten required any more outside prompting. Generally, that was effectively supplied by the requested intervention of his medical society or colleagues. Usually, a relatively short stay in an approved private hospital was sufficient. In rare instances, it was necessary to obtain permission from the Lexington hospital for his admission there, and the results were effective. From this experience we can generalize that "cure" or long abstinence can be expected from about 90% of the patients in this highly specialized group.

As indicated, volunteers for civil treatment for narcotic addiction were rather rare, perhaps one or two a month. The typical procedure in Illinois then is under the penal provisions of the law which produce the only appreciable work load of addicts to be treated. Of these, a very small proportion - those with little or no criminal background - is given the opportunity to accept commitment as civil addicts. Most of the remainder are handled as misdemeanants under jail sentence for detoxification and treatment and then under probation follow-up against relapse. In Chicago, a special ward has been established at the Bridewell Hospital to facilitate detoxification. When the addict has served his sentence of at least 90 days, he emerges from a drug-free environment to a probationary status.

Within its financial and personnel resources, the Cook County (Chicago) Adult Probation Department has assigned particularly qualified probation officers to this work. These endeavour to supply the probationer with whatever the community has available in the way of work opportunity, financial support, and other social services. Also, in a supervisory programme are a number of parolees from the state reformatories and penitentiaries who are included because of their record of' narcotic trafficking or narcotic addiction. These are under the supervision of the parole agents. Parole and probation people are responsible for the carrying out

of the supervisory programmes. The State Division of Narcotic Control sets the standards for and provides certain tests to ascertain if there has been a relapse to narcotics.

Early in the programme, the division enlisted the services of Coye Mason, M.D., a Chicago physician who has taken a far-reaching interest in the operation. It was decided that the chemical tests incident to the physical examination of the subject would include not only Nalline but urinalysis. The subject, in addition to receiving a Nalline injection to determine pupillary response, also submits a specimen of his urine. When the Nalline test is negative and it and other criteria indicate abstinence from opiates, the urine specimen is discarded in usual practice. However, if the Nalline indication is positive or equivocal or the subject admits to the recent use of narcotics, or there are other indications of it, a urinalysis is completed for its corroborative value. The dual procedure probably has an additional benefit in that it deters some relapsees from considering ways and means of" beating" just one type of test. The Illinois Division of Narcotic Control has attempted to simplify and shorten the methods of urine analysis for the detection of opiates. It has suggested that research programmes be conducted in the hope of developing simple methods for detecting opiate intake in addicts.

As a new programme, the Illinois follow-up and testing scheme for addicts developed very slowly. It was necessary to carefully train the personnel who would be concerned with it. The desired physical facilities did not exist, and although progress has been made in that direction, these still are not adequate. (In the writer's opinion, the Illinois programme would be enhanced if a minimum security type of hospital-detention facility were established near Chicago.)

Nevertheless, the experience with follow-up supervision of detoxified addicts in Illinois seems significant. The evaluation of results in this field must be based on empirical judgements. It would be almost impossible to devise a suitable check group. Nevertheless, in the opinion of experienced narcotic specialists, the tests seem to deter relapses, to prolong periods of abstinence, and to detect recidivism promptly. The Illinois operation tends to confirm the Alameda County, California (Oakland) experience with the benefits of Nalline as a valuable and efficient tool in the effective probationary and parole supervision of detoxified opiate addicts.

The Illinois system, when finally developed to a capacity to deal with a substantial portion of the Illinois addict population, may well be an example of an efficient, economical programme to restore many addicts from drug use.

Other programmes

Several other state or local programmes in contemplation or inception might be mentioned. In Philadelphia, there is planned an alcoholic centre in the Department of Psychiatry in the Philadelphia General Hospital, which will have complete in-patient, out-patient, day hospital and follow-up facilities for alcoholic and narcotic addicts. The Pennsylvania Board of Parole has organized in Philadelphia (where more than 80% of the narcotic cases occur) a special parole unit for the close supervision of parolees who were narcotic addicts. This is patterned after the project of the New York State Division of Parole heretofore referred to in this paper.

The State of Minnesota might be mentioned as somewhat typical of many regions in the United States where the present rate of narcotic addiction is relatively light. With a population of a little less than 3? million, of which 1,400,000 are concentrated in the metropolitan area of Minneapolis-St. Paul, this state has about 140 narcotic addicts, according to the latest count of the Federal Bureau of Narcotics. A few decades ago, Minnesota had an addict population several times heavier, and it was the centre of a substantial heroin

traffic. Due perhaps principally to a programme of intensive law enforcement and the consistent imposition of heavy sentences on traffickers, the present more favourable situation has been attained. At Willmar, Minnesota, the state maintains a hospital for inebriates including alcohol and narcotic addicts. Some years ago this institution came to the attention of the writer in connexion with its high percentage of success in the rehabilitation of a few addicted physicians. In 1960 the hospital admitted only seven narcotic addicts, either through voluntary application or under probate court commitments. A 90-day treatment programme is contemplated. The hospital has no facilities for follow-up treatment of addicts.

Compulsion in treatment

In this country and elsewhere, there sometimes is debate as to whether a narcotic treatment programme should have compulsory features. If the addict does not voluntarily seek and persist in treatment, should he be required to accept it ? To this writer it appears that some programmes for "voluntary" detoxification and treatment of the addict are not exactly voluntary. It may require nothing more than a friendly suggestion to an addicted physician or a person of similar character to cause him to take steps for treatment. In areas where these comprise many of the recognized addicts, the hidden compulsion behind the "voluntary" approach may be sufficient. And of course it is true that some addicts of their own initiative do manage and complete treatment. These should not be of great concern. Very likely they will never be the subject of official attention. In the American situation, the experience of the hospitals at Lexington and Fort Worth, numerous tests in New York, the Detroit experience, the history of civil addict treatment in California, the experience with voluntary civil addict commitments in Illinois, or rather the lack of them, all indicate without a single exception that the voluntary approach is inadequate, that it results in a waste of public money and in a dissipation of critically short medical talent and facilities. Some local narcotic hospital projects in this country have failed because of lack of authority in the programme. More accurately, in some cases, they failed because the responsible authorities, for various reasons, did not utilize the authority available to them.

General comments

As has been said, the narcotic addict can be looked on as the carrier or transmitter of a most dangerous disease. To use another figure, he serves as a catalytic agent to transmute into drug addiction the juxtaposition in the community of opiates and susceptible persons. In the opinion of this author, sound legal and medical concepts will not permit such an addict to remain in the community free to spread contamination and destruction, if practicable and relatively effective measures can be developed to remove him as a danger. It is the mechanics of these, both legal and medical, where the great difficulty lies. The mechanics can be so complex as to be self-defeating. In a Kelynack Memorial Lecture given in London in 1960, Dr. Harris Isbell aptly stated that while addiction in first view seems to be a narrow and limited field, one finds on examination that it is extremely complex. That statement can as well be applied to the smaller field of addict control. In *What's New,* No. 221, winter 1960, published by Abbott Laboratories, North Chicago, Ill., Dr. Murray Diamond, Medical Officer in charge of the Lexington Narcotic Hospital, expressed his view that the total management programme for drug addiction is a joint function and mutual responsibility of law enforcement, the healing agencies and the community agencies. He suggested that a complete programme should include early identification of the psychiatrically ill subjects (drug addicts), their prompt hospitalization in a drug-free environment with withdrawal of the drug under professional supervision. The hospital treatment should include physical and medical rehabilitation plus an individually determined course of psychiatric care, which might include individual or group psychotherapy as well as vocational training and rehabilitation. Dr. Diamond suggested there must be pre-discharge plans for the aftercare of the patient when released to the community. This aftercare should include health education, available psychiatric or

psychological counselling, family and social adjustments and employment opportunities.

Obviously to completely put in being a programme such as is outlined by Dr. Diamond is a complex undertaking. In much of this country and in much of the world where narcotic addiction is a severe problem, it would not be quickly attainable. Rather it is a goal to be sought.

Dr. Walter C. Alvarez, a much respected dean of medical writers in this country, once recommended in a syndicated newspaper article [*Chicago Daily Tribune,* 8 Dec. 1960] a more simplified approach. He cited experience with addicts going back more than 50 years. He suggested that the addict who did not have motivation for cure be taken from the community, isolated in pleasant circumstances on an island and be given work to make him as self-supporting as possible. This is of course the time-tested medical principle of quarantine when better remedies are not available.

It is to be hoped that in the adoption, modification or adjustment of the several programmes now being tried that a workable, economical, feasible and effective procedure for opiate addict control may be evolved. At the least it should include machinery for quickly identifying the addict as such, for removing him to a custodial environment where he can be disintoxicated and given the medical and psychiatric support which is available. After physical restoration in a custodial setting he can be released to the community under a follow-up programme which, in addition to what it can offer in the way of medical and social agency supervision, should provide for close checking for relapse to drugs, through systematic testing. Should he relapse, the addict must be promptly re-committed for subsequent re-release after additional treatment.

In general, the effect would be to offer the addict, after initial disintoxication and physical build-up, the opportunity to live freely in the community so long as he remains drug free. The alternative, if he relapses, would require that he remain drug-free in protective custody. It is this writer's opinion that, while some addicts might relapse frequently, and more might relapse infrequently, a large proportion would find in abstinence the easier choice and would remain drug-free.

Some narcotic control authorities have expressed misgivings on any over-concentration on addict control. In operations of this sort there is sometimes a tendency to consider the latest solution proposed as the only solution rather than just an additional weapon to be added to the existing armamentarium. If not intelligently administered there is the risk that addict hospitalization programmes may be taken advantage of by addicted felons to evade more severe sanctions of the law. There is a risk that under some conceptions an addict hospitalization programme would make the addicted narcotic peddler a priviliged criminal relatively immune from the severe type of penalties thought desirable for narcotic peddlers and drug controls thereby be loosened. These dangers must be recognized and avoided.

It cannot be said that at this point there is in effect in the U.S.A. any comprehensive programme for the control of the opiate addict as such. However, it is evident that much is being done in the way of trial experiments and in initiation of new programmes.

How effective this effort will be will be apparent only if and when operating procedures can be developed which are legally and medically sound and economically realistic, which will enable our society to reach out and bring into control and treatment an appreciable segment of the addict population.